THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 25 1957

37626 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9670

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1. Length of stay in 1b 25 24 hrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY
c. CITY OR TOWN St Louis Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3019 So. Jefferson Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First JAMES Middle Last HUTCHISON

4. DATE OF DEATH Month OCT Day 15 Year 1957

5. SEX M. 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Mar. 15 1892 9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME John S. Hutchison
13b. MOTHER'S MAIDEN NAME Elizabeth Boswell
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW #1
16. SOCIAL SECURITY NO. 499-01-3603A
17. INFORMANT Mrs. Lula Howeler Address 5645 Cote Brilliante

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 33 1/2
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 9/12/57 to 10/15/57 and last saw her/him alive on 10/15/57
Death occurred at 12:40 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert F Owen, M.D.
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 10/14/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Oct 17 57
23c. NAME OF CEMETERY OR CREMATORY National
23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

24. FUNERAL DIRECTOR McLaughlin ADDRESS 2301 Lafayette
25. DATE RECD. BY LOCAL REG. OCT 16 57
26. REGISTRAR'S SIGNATURE Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

MJB

Health, & Welfare Public Service

S. 300 1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student ..... Signed H. G. Farris

Signature of Student Embalmer

Licensed Embalmer No. 3384

P. O. Address H. Farris

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.